Witness Name: Scottish Care
Statement No.: 1
Exhibits: N/A
Dated: 11 July 2023

UK COVID-19 INQUIRY

CORPORATE STATEMENT OF SCOTTISH CARE

I, Donald Macaskill, Chief Executive of Scottish Care, will say as follows on behalf of Scottish Care: -

SECTION A: A BRIEF OVERVIEW OF SCOTTISH CARE'S HISTORY, LEGAL STATUS AND AIMS

1 Scottish Care is a membership organisation representing the independent social care sector in Scotland. It works with members and stakeholders in social care to create conditions for sustainable human-rights-based care and support.

2 Scottish Care is a registered charity (charity number SCO51350) and a company limited by guarantee (company number SC243076). It was incorporated in January 2003 and registered as a charity with the Office of Scotland's Charity Regulator on 19 October 2021.

3 Its charitable purpose is "*the relief of those in need by reason of age, ill-health, disability, financial hardship or other disadvantage*". To achieve this purpose Scottish Care's objectives are to:

3.1 promote, maintain, improve and advance, for the benefit of those referred to in its charitable purpose, organisations which offer care and support services in Scotland;

3.2 promote the common interests of organisations which offer care to those referred to in its charitable purpose and advance their position to the advantage of their members; and

3.3 assist the sector in this field to develop their services and standards.

4 Scottish Care engages with key stakeholders, including the Scottish Government, local authorities, the Care Inspectorate, the Scottish Social Services Council, the Convention of Scottish Local Authorities ("COSLA"), Healthcare Improvement Scotland and NHS Education Scotland. In doing so, Scottish Care advocates for its members on issues that impact them at a national and local level. It also undertakes robust quantitative and qualitative research, often in partnership with public bodies and/or universities, in order to highlight the key issues facing the independent care sector and those to whom the sector provides care.

SECTION B: A BRIEF DESCRIPTION OF THOSE THAT SCOTTISH CARE REPRESENTS

5 Scottish Care has 350 members which cover approximately 900 services (with some members operating several care homes or organisations that provide care at home).

6 Scottish Care's members are independent social care providers in Scotland which deliver residential care, nursing care, day care, care at home and/or housing support services. Its members include private, not for profit, employee-owned and charitable organisations. Scottish Care represents more of such providers than any other representative body in Scotland.

7 Its membership includes organisations of varying types and sizes including providers of single facilities, small and medium sized groups, national providers, and family run services. Its members deliver a wide range of registered services for older people as well as those with long term conditions, learning disabilities, physical disabilities, dementia, and mental health problems.

8 Over the course of the pandemic, Scottish Care's members were at the forefront of the frontline response caring for older people and those with disabilities in residential settings and/or in those individuals' homes.

SECTION C: A BRIEF OVERVIEW OF THE WORK OF SCOTTISH CARE IN SUPPORTING AND REPRESENTING ITS MEMBERS

9 Scottish Care has been asked to provide a brief overview of its work in supporting or representing its members between 1 January 2020 and 31 December 2022 insofar as this work relates to the response to the COVID-19 pandemic by the Scottish Government.

10 It was clear from an early stage that the pandemic would have an unprecedented impact on the social care sector and that the sector would require support in navigating this new and challenging landscape. Scottish Care sought to support its members throughout this period through a variety of means and channels.

11 As a national representative body Scottish Care was also at the heart of debate and discussion during this time, providing detailed and vocal response to the numerous issues that were faced by the social care sector.

Advice and guidance provided to Scottish Care members

12 A key priority for Scottish Care throughout the pandemic was ensuring that its members were aware of legislative changes and guidance issued by the Scottish Government, Public Health Scotland ("PHS"), COSLA and the Care Inspectorate and the impact that such changes and guidance would have on their operations.

13 Due to the emerging knowledge of the nature and spread of the virus, guidance changed frequently particularly at the outset of the pandemic. Care providers were operating in extremely challenging circumstances and were often facing staffing issues (as described at paragraphs 110 and 111 below). Therefore, it was essential that information was communicated quickly and effectively by Scottish Care and that members had forums in which they could share information and best practice.

Guidance and communication

14 Scottish Care first published guidance for its members in relation to COVID-19 on 24 February 2020. That guidance contained general information about the virus which was based on Public Health England advice which had been published at that time. It also contained specific information for social care providers in relation to the

development of standard operating procedures, personal protective equipment ("PPE") and resilience planning. This was the first guidance in relation to COVID-19 developed specifically for the social care sector in Scotland and was amongst the first in Europe.

15 After this initial publication, Scottish Care did not produce any further guidance during the pandemic and instead directed its members to guidance produced by the Scottish Government, PHS, COSLA and the Care Inspectorate.

16 On 11 March 2020, Scottish Care issued an urgent letter to all of its care home members asking them to give serious consideration to restricting access to their care homes, if they had not already done so.

17 0n 13 March 2020, Scottish Care created a platform on its website titled "*Information on Coronavirus (COVID-19) Members Area*" ("the COVID-19 Members Area") for the purpose of alerting its residential care and care at home members to new and frequently changing information and guidance. It contained the most recent versions of all relevant Scottish Government, COSLA, and PHS guidance, publications and letters. In addition, information relating to wellbeing helplines and resources, PPE, travel arrangements and any other key updates were added to this platform. This platform was updated regularly throughout the pandemic, often several times a day in early 2020.

18 Scottish Care also set up discussion boards within the COVID-19 Members Area of its website to provide its members with a place to ask questions and mutually support each other.

19 As CEO of Scottish Care, I wrote weekly blogs from March 2020 providing updates on the work that Scottish Care was doing in response to the pandemic and highlighting key issues for the sector. From 12 April 2020, I began uploading blog posts to the COVID-19 Members Area titled "*CEO Review of the Week*" which included weekly roundups of important news, information and guidance for members. These continued throughout the pandemic, although they were issued on a fortnightly, rather than weekly, basis from 13 March 2021.

Webinars/Surgeries

20 In order to actively support its members, Scottish Care began running webinars on COVID-19 twice a week (every Tuesday and Thursday) from 17 March 2020. These sessions were hosted by Karen Hedge, Scottish Care's Deputy CEO, and me. They were predominantly for Scottish Care members, however a number of webinars were also made available to non-members.

21 While the majority of these early webinars covered a range of issues relating to COVID-19, the session on 14 April 2020 was dedicated to PPE and on 24 April, 5 May and 14 May 2020 Scottish Care hosted the Care Inspectorate, PHS and Professor Graham Ellis (who was at that time the National Clinical Adviser for Ageing and Health) respectively as guest speakers.

22 From 19 May 2020, these sessions were renamed as 'surgeries' in order to reflect their interactive nature. The purpose of the surgeries was to provide a forum in which members could ask Scottish Care questions and share information with each other.

23 They also provided Scottish Care with the opportunity to obtain feedback from its members in relation to what was happening in the care sector in each part of the country. This supplemented the daily intelligence it was receiving from its regional staff based throughout Scotland. This enabled Scottish Care to ensure it could advocate on behalf of its members facing challenges specific to particular regions in addition to the national challenges being faced by the sector.

24 Some surgeries focused on specific topics such as bereavement, testing, wellbeing and the Scottish Government's "Safety Huddle – Turas Care Management" tool. Scottish Care continued to host guest speakers at some of these surgeries, including representatives from the Scottish Government.

25 Surgeries began being held once per week from Tuesday 9 June 2020. Scottish Care held a total of 53 webinars or surgeries in relation to COVID-19 throughout 2020.

26 Weekly surgeries continued throughout 2021. These were supplemented throughout the year by a number of webinars on specific topics with guest speakers, including Professor Jason Leitch, Clinical Director, Healthcare Quality and Improvement,

Scottish Government and Dr Syed Ahmed, Senior Medical Officer, Scottish Government on vaccination; representatives from the Scottish Government in relation to care home visiting; and Hugh Masters, Associate Chief Nursing Officer, Scottish Government, on care at home testing.

27 From 11 May 2021, the surgeries for members changed from being directed to all members to alternating weekly between sessions for care home members and members delivering care at home.

28 A total of 57 Scottish Care surgeries and webinars took place in 2021.

29 In 2022, Scottish Care hosted 42 surgeries and webinars. These included two sessions with the Scottish Government in relation to facemask and testing guidance.

30 From 28 June 2022, Scottish Care's weekly surgeries reduced to fortnightly surgeries - there was one session per month for care home members and for members providing care at home. This schedule reverted to weekly sessions for all members on 25 October 2022 due to the challenges that the care sector faced as winter approached.

Sector meetings

31 During the pandemic, Scottish Care hosted virtual meetings of the Regulatory Fora. This was a group which had been established by Scottish Care before the pandemic to bring together social care providers with regulatory bodies including the Care Inspectorate, the Scottish Social Services Council and Disclosure Scotland to talk about workforce issues.

32 During the pandemic the Regulatory Fora provided an opportunity for regulatory bodies to hear from and present to social care providers. Some meetings also included representatives from the Scottish Government's National Workforce Strategy team and its Mental Health and Wellbeing team.

33 Scottish Care also hosted meetings of the Strategic Nursing Group which was a forum in which nursing and clinical staff could share their experiences of the management of the pandemic. Scottish Care obtained information at this group which informed its contributions at meetings of the Scottish Government's Clinical &

Professional Advisory Group for Care Homes ("CPAG") and at meetings of sub-groups of CPAG, particularly in relation to the development of visitor guidance.

34 Separately, Scottish Care's Local Independent Sector Leads extended or established local networks for social care providers in areas throughout Scotland. They hosted virtual meetings which were critical to the dissemination of information to providers. These meetings were also invaluable sources of information in relation to what was happening at a local level. Questions and concerns which were raised at these meetings were passed by the Local Independent Sector Leads to the Scottish Care National Team so that the contributions it made on a national stage could take account of local context and the challenges being faced in different areas.

Media

35 As discussed further below, the care sector featured heavily in the media throughout the pandemic and was often the subject of criticism. Scottish Care provided media statements on behalf of its members and the care sector in Scotland to respond to this criticism and provide information on the challenges that the sector was facing including in relation to PPE, testing, care home visiting and vaccination.

36 During this time, Scottish Care members and other social care providers were experiencing increased media interest. Scottish Care developed a Media Toolkit in May 2020 to help providers with dealing with media enquiries. It also offered to assist its members with writing media responses and did so on a number of occasions.

Tech Device Network

37 Scottish Care worked with Jennifer Nimmo-Smith, director of Electric Shores Publicity, to develop the Tech Device Network ("the Network") to help keep residents in care homes or those receiving care at home connected with their family and friends while social distancing and restrictions on visiting were in place.

38 The Network was launched on 26 March 2020 and Scottish Care invited businesses, organisations and individuals to donate spare technological devices to care homes. Scottish Care asked that any devices donated were in good condition and that they had been cleared of any personal data. The Network was predominantly managed via online donation and request forms which were available on Scottish Care's

website. Those who had devices to donate could complete a donation form and Scottish Care would then liaise with them to collect the device. It was predominantly tablet devices that were donated but some laptops and smart phones were also received.

39 Those providing social care could request a device using a request form and Scottish Care then organised the delivery of devices to care homes and care at home providers who had made such requests. This initiative began to wind down when national measures were developed by the Scottish Government to support access to devices and connection for those accessing care services and had substantially ceased by October 2021.

40 Scottish Care also shared resources on its website to help social care workers who were less familiar with using technology develop their skills so that they could support those to whom they provided care. It also shared details of apps and initiatives that social care services could use to help residents and service users maintain vital social connections.

Representation of Scottish Care's members and the wider social care sector

41 Throughout the pandemic Scottish Care represented members and the wider independent social care sector in Scotland by attending meetings and working groups convened by the Scottish Government. It also maintained regular and direct communication with Scottish Government officials on key issues including the financial sustainability of care providers, testing, regulatory and other oversight, PPE and workforce related matters.

42 Scottish Care participated as subject matter experts in meetings of groups such as the CPAG and the Pandemic Response in Adult and Social Care Group ("PRASCG") and liaised with the Scottish Government and other stakeholders in relation to the development of guidance which impacted the sector.

43 Scottish Care also published joint media statements with other organisations such as the Royal College of General Practitioners Scotland (RCGP Scotland), the Royal College of Nursing Scotland (RCN Scotland), Marie Curie and the Five Nations Care Forum in order to represent the position of social care providers and to advocate on

behalf of those to whom social care is provided. As part of the Five Nations Care Forum, Scottish Care attended meetings with leaders of care associations across England, Wales, Northern Ireland and the Republic of Ireland to share information on the pandemic response, understand any differences between the responses in each nation, identify and share best practice and provide mutual support.

44 Appendix 1 lists the formal instances of engagement Scottish Care had with the Scottish Government, however, some of the key steps that Scottish Care took to represent its members and the wider social care sector in relation to key issues during the pandemic are summarised below.

Facilitating access to PPE

45 Obtaining access to adequate PPE was a key concern for care providers in Scotland at the outset of the pandemic. Scottish Care alerted the Scottish Government and NHS National Services Scotland ("NSS") on 5 March 2020 that there were critical shortages of PPE in the care sector, that costs for available products had become exorbitant and that there was a need for a national flexible and responsive delivery mechanism.

46 Scottish Care sought to resolve issues relating to the availability of PPE for the care sector by escalating concerns, which included engaging in constructive discussions with the then Cabinet Secretary for Health and Sport, Jeane Freeman.

47 Elaine Rae, a Scottish Care consultant whose position was funded by the Scottish Government, liaised directly with NSS in relation to the issues faced by the social care sector and Scottish Care helped NSS to develop solutions to support the sector. The establishment of PPE hubs by NSS on or around 17 March 2020, which were replaced by direct delivery to care homes followed by a triage system, eased the pressure faced by the sector in connection with obtaining PPE.

48 Scottish Care also worked to resolve issues in relation to the amount of PPE that was initially being allocated to social care providers at PPE hubs. NSS based its modelling for the demand for PPE on the number of staff and the number of 'sessions' for which PPE was required. A session was defined as a two-hour period. Difficulties relating to allocation arose as social care staff are not able to calculate

PPE requirements based on two-hour periods because within any given two-hour window they may have to attend to several residents within a care home or make several visits to individuals receiving care in the community. Social care staff needed to change PPE between contact with each individual to whom care was being provided.

49 This was an issue which was resolved very quickly and by 26 March 2020 NSS had begun proactively asking for Scottish Care's input on decisions relating to PPE that affected the social care sector. However, there continued to be practical issues with social care staff accessing sufficient supplies of PPE. For example, Scottish Care received reports of members being provided with insufficient supplies of gloves at PPE hubs as those staffing the hubs did not appreciate the number of times per day that social care staff members would have to change gloves.

50 Scottish Care also liaised directly with PPE suppliers throughout 2020 to establish supply chains for the social care sector and supported consortium purchasing of PPE by a group of providers. From March 2020 until the end of 2020, Scottish Care provided a weekly update for its members with the latest PPE prices and supplier information.

51 Throughout 2021 and 2022 Scottish Care continued to contribute to discussions concerning the development of policy in relation to PPE hubs.

Clarification of guidance

52 Scottish Care engaged extensively with the Scottish Government to seek to clarify guidance about the PPE that was to be worn by those working in care homes and those providing care at home.

53 Scottish Care members raised concerns at Scottish Care surgeries about the lack of clarity at a local level as to which type of PPE should be worn by staff and when. Scottish Care frequently raised this issue with the Scottish Government and PHS by email.

54 On 30 March 2020, Scottish Care, RCGP Scotland and RCN Scotland wrote jointly to the Cabinet Secretary for Health and Sport to express concerns in relation to the availability of PPE to those providing care in the community. Together these

organisations called for guidance recommending a consistent approach regarding the level of PPE required across both acute and community settings.

55 On or around 19 May 2020 confusion was caused by conflicting guidance being issued in relation to the type of gloves that should be used when providing personal care to social care service users. National guidance was that vinyl gloves should be used but some HCSPs were specifying that nitrile gloves, which were substantially more expensive, were required. There was no national guidance in place specifically for social care providers. Scottish Care liaised with NSS who agreed to issue further guidance on this issue on 22 May 2020.

Testing of residents upon admission

56 Scottish Care advocated from early March 2020 that there needed to be robust clinical assessment and testing of residents entering care homes both from the community and acute NHS settings.

57 In a number of public statements and in meetings with officials and ministers Scottish Care stated that the lack of trust which had developed between many providers and discharge teams meant that there would be a reluctance to accept individuals being admitted back to or into care homes. This lack of trust had developed over a number of years, especially during times of pressure in relation to delayed discharge in acute settings. In such times, the care sector noted that proper discharge practices were not always followed. For example, care home staff experienced individuals being discharged into their care without notes and at times without their required medication. It was also common for individuals to be discharged late on Fridays when it was difficult for care staff to rectify these issues. In some cases, although an individual had been assessed as requiring residential care, it became clear to care home staff within hours of the individual arriving that they required 24-hour nursing care. In some, but not all, areas of the country care sector staff felt that there was a lack of partnership working from colleagues in hospital discharge teams. These factors had created a 'trust deficit'.

58 There were times during the pandemic when care homes were concerned about accepting new residents due to their lack of confidence in the discharge practices that were being adopted at the time. The concerns were for the health and safety of

their existing residents and their staff. There was a sense in the care sector that pressure was being put on providers who were signatories to the National Care Home contract to admit new residents (even though the obligation under that contract is only to accept residents who are appropriately assessed).

59 Initially, the media was critical of care home providers for not making themselves available to take new residents to reduce the pressure on the NHS. However, within weeks there was a change in perspective and questions were being asked about why individuals were being discharged to care homes.

60 As an organisation Scottish Care advocated that all individuals entering a care home should be treated as if they were COVID positive and therefore barrier nursed for an initial fourteen days.

61 It took some time for the Scottish Government to make a policy decision that stricter measures should be adopted and for this to be reflected in guidance from PHS. Scottish Care was still addressing instances of poor discharge practices with CPAG, with Professor Graham Ellis and with Hugh Masters in May and June 2020 despite the official policy having changed by this time. Scottish Care received reports from members that COVID-19 tests had not been performed on individuals who had been admitted to care homes despite operators having received assurances to the contrary and that some acute settings were not following the guidance in relation to discharge practices which were in place at that time.

62 It also took some time for policy and practice to move towards testing both symptomatic and asymptomatic individuals, despite early calls from Scottish Care for all residents to be tested.

Testing of staff

63 From March 2020 Scottish Care advocated that it was critical that priority was given, even in the context of limited test availability, to staff working in care homes who were likely to pose the greatest risk to those being supported in these settings.

64 Scottish Care also made a number of calls for the workforce providing care at home to be similarly prioritised due to it having regular close contact with clinically vulnerable individuals.

Visiting restrictions, representations in relation to human rights and contribution to the development of guidance

65 At the start of the pandemic Scottish Care encouraged its members to lockdown before national lockdowns came into force and to restrict visiting in accordance with the developing guidance – it believed this to be proportionate given the risk and in accordance with the legitimate aim of keeping people safe and well.

66 As time passed, and as early as April 2020, Scottish Care made representations to the Scottish Government that the complete restriction of visiting to care homes (save for limited exceptions in relation to at end-of-life care) was increasingly disproportionate and failing to meet the pastoral and care needs of individuals. Scottish Care also highlighted the traumatic effect this was having upon families. Throughout the pandemic Scottish Care's national staff sought to work with local providers to ease restrictions when these were allowed, and Scottish Care made in depth contributions at each stage of the development of the various strands of visitor guidance published by the Scottish Government.

67 Scottish Care continually called for a human rights impact assessment to be carried out in relation to the restriction of visitors to care homes. These calls were made by Scottish Care at meetings of the CPAG and reference was made in blogs published by Scottish Care to the need for a human rights-based approach to be adopted in relation to visiting in care homes.

68 On 3 April 2020 the Scottish Government published the "*COVID-19 guidance: ethical advice and support framework*" which provided guidance on an ethical approach to clinical decision-making during times of increased demand for health care resources. Scottish Care, and other representative groups, including Age Scotland, Inclusion Scotland and the Scottish Commission for People with Learning Disabilities, publicly raised concerns that the guidance did not provide assurance that such decision making would be non-discriminatory and based on an assessment of human rights. This guidance was subsequently updated following input from the Scottish Human Rights Commission, Inclusion Scotland, and the Equality and Human Rights Commission and an Equality Impact Assessment was undertaken.

69 During the pandemic Scottish Care received reports from care home members that they had been sent packs of blank 'do not attempt cardiopulmonary resuscitation' ("DNCPR") forms by GPs, presumably for residents within their care, without any previous discussion having taken place about putting DNCPR orders in place. Care home staff found this experience distressing.

70 I was a member of the Community National Palliative Care Group and Acute Palliative Care Group at which concerns were also raised about the use of DNACPR forms during the pandemic.

Financial support

71 The immediate financial pressures faced by independent social care providers, not least due to the increased costs of PPE and those associated with the loss of staffing, meant there was an urgent need to establish financial support. This process took some time to establish and for the relevant criteria to be developed. Throughout this time Scottish Care worked with the Scottish Government, COSLA and Chief Finance Officers of Local Authorities to secure financial support for the care sector.

72 89 per cent of care home provision and approximately 55 per cent of care at home provision in Scotland is delivered by independent providers - most of which are small, locally and/or family run businesses.

73 Business support funds that were available to small businesses during the pandemic generally provided organisations with a lump sum that was designed to help them withstand the impact of the pandemic. However, social care providers were not eligible to apply for these funds and a separate funding process was developed by the Health and Social Care Directorate within the Scottish Government specifically for social care providers.

74 Social care providers could apply for funding for the additional costs that they incurred as a direct result of the pandemic. Payments were referred to as sustainability payments. Providers who were signatories to the National Care Home Contract could also claim under-occupancy payments where their care homes were under-occupied as a direct result of the pandemic. Providers who were not signatories could also claim under-occupancy payments where a local authority

commissioned services from them or would usually have done so had it not been for the pandemic.

75 Local authorities were tasked with receiving and assessing applications for sustainability and under-occupancy payments from the care sector and distributing the relevant funds.

76 The applications for sustainability payments had to be made retroactively and required to be heavily evidenced - social care providers had to provide extracts of their ledgers or their management accounts showing the increase in their operating costs for the period for which they were seeking payment. At times providers had to undergo an open book exercise in order for sustainability payments to be granted.

77 Additionally, the terms on which sustainability and under-occupancy funds were available to care providers changed on a number of occasions during the pandemic and Scottish Care dedicated significant time to trying to resolve individual and collective complaints and failures in these systems. It negotiated with COSLA and local authorities' Chief Financial Officers on behalf of the sector and provided conflict-resolution where it was needed, for example in situations where applications for under-occupancy and/or sustainability payments were refused or insufficient funding was granted.

78 Scottish Care also directly supported its members to navigate the systems of funding that were potentially available to them. It collated opportunities to explore funding and highlighted these on its website and hosted webinars to support members with the processes for obtaining funding.

79 There were inconsistencies in the approach being taken to applications for under-occupancy and sustainability payments by local authorities. Local authorities did not have sufficient resources to process the applications and at times did not explain why applications were refused or partially granted.

80 Scottish Care liaised with COSLA to highlight the pressures that the sector was under and the challenges that applicants were having when attempting to access sustainability funds. Scottish Care also ran webinars for the Chief Financial Officers

of local authorities to help them to navigate the social care sector and understand the challenges that it faced.

81 The Social Care Staff Support Fund was established by the Scottish Government in June 2020 in an attempt to ensure that social care workers would not face financial hardship as a result of testing positive for COVID-19 and having to isolate. In such circumstances, social care providers were required to pay social care workers and then recoup the costs from their local authority. There were however long delays in payments being reimbursed to social care providers and Scottish Care worked closely with trade unions, COSLA and the Scottish Government to try to resolve this issue.

82 Scottish Care also ran a webinar for social care providers to answer questions about the £500 payment that was made available for health and social care staff in February 2021 and disseminated information about how this payment could be accessed.

83 Separately, to address staff burnout and the large number of vacancies in the care sector, Scottish Care continued to call for social care and nursing staff in the independent sector to have pay parity with the NHS and lobbied for change in relation to fair pay.

Research

84 Scottish Care continued to undertake research throughout the period from 1 January 2020 to 31 December 2022 much of which related, directly or indirectly, to the experience of the social care sector during the pandemic. The publications related to this research are listed in Appendix 2.

85 Scottish Care's research activities have helped to inform its contribution to public debate and its approach in supporting the sector recover from the pandemic.

SECTION D: THE KEY ISSUES AND IMPACTS EXPERIENCED BY SCOTTISH CARE'S MEMBERS

86 Scottish Care has been asked to provide a brief overview of the key issues and impacts experienced by those it supports and represents as a result of the COVID-19 pandemic in Scotland and the response by the Scottish Government.

Increased risk of spread of COVID-19 within care settings

87 At the outset of the pandemic issues encountered by the care sector, such as the shortage of PPE, lack of access to testing, and the discharge of patients from acute clinical care settings without testing, increased the risk of the virus spreading, particularly in care home settings.

PPE

88 Although NSS worked with Scottish Care to quickly reduce the PPE supply issues faced by the care sector, during the first phase of the pandemic the sector faced several challenges including:

88.1 the inconsistency within national guidance on what PPE should be worn and in what contexts which led to an unnecessary politicisation of its use. By way of example, statements were made by trade unions suggesting that some independent social care providers were not allocating the appropriate PPE to their staff. However, providers were acting in accordance with national guidance which prescribed different PPE requirements for staff working in social care than for those working in healthcare. There were occasions on which media outlets shared photos taken of staff providing care on social media with comments stating that they were not using PPE in the right way. Social care providers and frontline staff felt that they were being unfairly criticised when access to PPE was not within their control. There was also a lack of clarity for homecare colleagues on when PPE should be worn. This arose from the fact that guidance had yet to be produced to take account of the circumstances in which such services were being provided;

88.2 a UK-wide prioritisation of PPE for the NHS which led to real difficulties amongst providers in being able to purchase PPE and included the requisitioning of materials upon entry into the UK;

88.3 a lack of recognition of the threats posed by what is now known to be an airborne virus and the nature of asymptomatic spread, which led to a delay in the introduction of guidance mandating PPE in care settings. Airborne and asymptomatic transmission was being discussed by the UK Scientific Advisory Group for Emergencies in February 2020 and concerns were being raised by the sector about the airborne nature of the virus in March 2020. However, messaging from the UK and Scottish Governments focused on a cough and touch risk within two metres and continued to do so for some time;

88.4 a lack of engagement with the sector by local authorities and health and social care partnerships ("HSCPs") to prevent the prioritisation of in-house supply. Some of Scottish Care's members felt that these bodies were prioritising the supply of PPE to the services which they owned. Scottish Care was informed of these concerns and raised them with local authority and HSCP PPE teams and the Scottish Government; and

88.5 a failure to mandate the use of PPE as a preventative resource especially in March and April 2020 when PPE was only available after positive or suspected cases had been identified.

89 These issues undoubtably increased the risk of COVID-19 outbreaks in care settings, despite the use of standard infection prevention and control measures. Risks to those working in the social care sector were also increased during this time when the impact of the virus was unknown and when vaccines were unavailable.

Testing following an outbreak

90 The initial practice adopted in relation to testing following the diagnosis of a COVID positive individual in a care home had an impact on the ability of care homes to manage outbreaks.

91 During the earliest responses by Public Health Scotland and HSCP, local authority and/or NHS Incident Management Teams only a proportion of care home residents

were tested during an outbreak and initially only those who were symptomatic. Accessing tests was a huge challenge for care home managers and staff and the lack of whole home testing made their use essentially confirmatory rather than preventative.

92 Separately, the lack of testing in homes where there was no known COVID positive individuals resulted in a failure to adopt a preventative approach to potential spread and outbreaks especially in those areas where there was known to be high community transmission.

Restriction of medical care for care home residents

93 The clinical guidance titled "*Nursing Home and Residential Care Residents and COVID-19*" that was issued by the Scottish Government on 13 March 2020 caused considerable confusion within the residential care sector and led to a belief that individual residents who were COVID positive should not be transferred to hospitals. Scottish Care's extremely limited opportunity to comment on this guidance before it was published is described in Section F below.

94 Although this guidance was later clarified, the practice of care home staff being strongly discouraged to transfer COVID positive residents to hospital remained. In many instances it was appropriate for the resident to remain in their care home but the presumption of a blanket ban in transferring residents was unhelpful and placed enormous pressure upon care home staff.

95 Many members of care home staff reported to Scottish Care a sense of 'clinical abandonment' in the first phase of the pandemic. Many care homes struggled to access GPs and/or to get GPs to come into care homes to treat residents. It appeared to those in the social care sector that a presumption had developed amongst medical professionals that no external clinical visits should be taking place. Scottish Care worked with senior officers of the RCGP to address this but as late as December 2020 it was in contact with Scottish Government officials regarding instances of GPs refusing to enter care homes.

96 This restriction of clinical care was hugely damaging to individuals with ongoing and developing clinical conditions and resulted in marked deterioration in the health and

wellbeing of residents. It also increased the strain on care home staff who could not obtain appropriate medical care for residents.

Impact of increased regulatory requirements, inspections and criminal investigations

Oversight and assurance systems

97 In May 2020 the Cabinet Secretary for Health and Sport announced arrangements for "*enhanced professional clinical and care oversight of care homes*" which instructed Health Boards and HSCPs to establish multidisciplinary teams to scrutinise and support care homes.

98 While the introduction of these arrangements was ostensibly an attempt to support stretched care homes, it led to considerable confusion within the sector. As a result, in addition to inspections from the Care Inspectorate, care homes were inspected and visited by teams from HIS, infection prevention and control specialists and appointees of the Health Board Nurse Director, among others.

99 This approach frequently resulted in contradictory advice and guidance being provided to staff and led to a clinical approach to care homes from practitioners who did not have any expertise in a social care context. In particular, infection prevention and control measures appropriate to an acute hospital setting were being imposed on care homes by staff from an NHS background who did not appreciate that care homes could not be treated in the same way as acute settings. An example of this was the failure of those from a clinical care background to recognise care homes as the homes of individuals with dementia. Personal items, which were often critical for residents' wellbeing, were assessed as infection risks and removed from residents' rooms often causing real upset to these residents.

100 Social Care staff felt that their experience and expertise was not respected by those who provided oversight and that their autonomy to make decisions in the best interests of their residents was reduced.

101 Over time the model improved in some parts of the country and it has been described as one of collaborative improvement. However, Scottish Care undertook research in 2021 which evidenced the considerable harm that resulted from such a

confused oversight and scrutiny model being imposed upon the sector. This included a significant reduction in staff morale during an already challenging time. The results of this research were published in Scottish Care's report *"The Ingredients for Growth: Care Providers Experience of Regulation and Oversight"* in November 2021.

The role of the Care Inspectorate

102 The approach taken by the Care Inspectorate during the early stages of the pandemic was proportionate and reasonable. By working with the sector, it was instrumental in establishing an audit process for available PPE and in the creation of a RAG system to determine risks associated with staff absences. The withdrawal of routine inspections by the Care Inspectorate also assisted in the control of the virus by reducing footfall in care settings.

103 However, over time there was a considerable deterioration in the working relationship between providers and the regulator as a result of:

103.1 the decision to establish inspections focussed solely on infection prevention and control requirements with the imposition of new scrutiny requirements in relation to the same;

103.2 the requirement introduced by the Coronavirus (Scotland) (No.2) Act 2020 for the Care Inspectorate to provide fortnightly reports to Parliament setting out which care homes had been inspected and the findings of those inspections. In practice these reports were often submitted before the findings were reported to providers; and

103.3 new inspection criteria in relation to infection prevention and control were developed and implemented without full engagement with the sector or information relating to the changes being appropriately disseminated. Providers did not receive training on how their practices should be adjusted.

104 Prior to the pandemic the Care Inspectorate had moved to a regulatory model which involved collaboration and engagement with the sector. However, during the pandemic providers felt that it was increasingly focused on scrutinising the sector as

opposed to working collaboratively with them to obtain improvements. This negatively affected the improvement in the quality of social care services that had occurred before the pandemic.

Operation Koper

105 In May 2020 the then Lord Advocate announced that the death of any care home resident due to COVID-19 or presumed COVID-19 was to be reported to the Procurator Fiscal. This decision and the subsequent reporting and investigation of such deaths has caused considerable trauma within the care home sector.

106 While Scottish Care recognises that this decision arose from a legitimate desire to provide assurance to the general public, its impact led to many skilled and experienced managers and staff leaving the sector and undoubtedly contributed to a less resilient response to the pandemic.

107 The same approach was not adopted in relation to deaths that occurred in hospitals, NHS specialist units or community settings. This distinction led to the care sector receiving negative media attention and a feeling within the sector that it was being disproportionately targeted by such investigations.

108 It also led to the development of a risk averse approach to the response to the pandemic due to providers' fear of criminal prosecution if there was to be a COVID-19 outbreak within their care home. This resulted in staff making more conservative decisions - for example when determining whether to admit new residents. In particular, some providers took a very cautious approach to allowing visitors into their care homes in circumstances where visiting was permitted by national guidance.

Impact of staff wellbeing and the reduction of experienced staff

109 The pandemic had an acute effect on the wellbeing of social care staff who were working on the frontline, caring for some of the most vulnerable individuals in Scotland in extremely challenging circumstances.

110 The failure to prioritise testing for social care staff resulted in staff having to take longer absences from work after coming into contact with a person who was COVID

positive. In contrast, by mid-March 2020 NHS staff were receiving tests following such contact so that they could return to work after a 48-hour period. This resulted in the sector having to operate with a reduced workforce despite the increased challenges it was facing. This led to staff shortages and also had negative financial impacts on social care staff who were, given their role, unable to work during such periods of self-isolation.

111 The social care sector faced unfair treatment from the media and wider public who frequently attributed COVID-19 outbreaks and deaths to care homes. Staff morale was severely affected and many experienced managers and staff left the sector as a result of the pressures experienced or after facing burnout, which resulted in even more strain being placed on the remaining workforce.

112 Staff began to feel that there was societal dissatisfaction with the service that they provided. Prior to the pandemic, staff felt proud of working in social care however Scottish Care has been told that some no longer feel this way due to a perceived change in public opinion of the sector.

Impact on financial viability of the independent care sector

113 The pandemic resulted in significant financial pressure being placed on care providers due to increased operating costs and decreased demand for their services.

114 As described in Section C above, social care providers had to apply retroactively for sustainability payments and accordingly had to incur the increased costs of providing services without any certainty as to whether such costs would be reimbursed. There were often substantial delays between applications being submitted, being granted, and payments being received which compounded this uncertainty. Applications also had to be resubmitted on a regular basis which increased the workload of social care managers at a time when the sector was under considerable pressure.

115 The availability of funding was regularly extended on the week, if not the day, that the fund was due to end. This type of intervention did not allow for longer-term financial viability and business planning and affected the stability of organisations.

There were a number of care home closures during the pandemic and due to its lasting financial impact coupled with the rising cost of living the sector is currently experiencing the highest level of care home closures in Scottish Care's existence.

SECTION E: ARTICLES, REPORTS ETC. PUBLISHED BY SCOTTISH CARE

116 Scottish Care has been asked to provide a list of any articles or reports that it or those it represents have published or contributed to, and a list of any written or oral evidence that is has previously given to any body about the impact on those it supports and represents as a result of the COVID-19 pandemic in Scotland and the response by the Scottish Government.

117 A list of the material which Scottish Care produced and/or contributed to can be found at Appendix 3.

118 Not included in this list are details of the frequent television and radio appearances I made to represent the interests of the care sector in Scotland throughout the pandemic.

119 A list of the evidence which Scottish Care provided to Committees of the Scottish Parliament and the Scottish Affairs Committee of the UK Parliament can be found at Appendix 3, Table 2.

SECTION F: CONSIDERATION OF THE SOCIAL CARE SECTOR DURING THE PANDEMIC

120 Scottish Care has been asked to provide its view on whether those it supports or represents were adequately considered when decisions about the response to the Scottish COVID-19 pandemic were made by the Scottish Government.

Pre-pandemic planning

121 There were several exercises undertaken by Scottish Government and its statutory partners to plan and prepare for a potential pandemic incident prior to January 2020. Although the majority of social care provision in Scotland is commissioned and contracted from the independent and third sector, social care providers were not involved in these exercises.

122 This was a missed opportunity to have robust cross sector strategic plans in place to help facilitate an effective response in an emergency situation. This contributed to a lack of awareness and understanding of the key issues affecting the sector in the early stages of the pandemic and the challenges that are specific to the provision of social care.

123 By contrast, there was engagement by the Scottish Government with the sector and Scottish Care in 2018 and 2019 in preparation for the UK's departure from the European Union including in relation to resilience planning. This engagement helped to enable a more immediate response by the Scottish Government in relation to the PPE supply for the care sector at the start of the pandemic.

Decision making throughout the pandemic

124 Throughout the pandemic the touchpoints and routes for decision-making were complex and varied. A variety of individuals and departments within Scottish Government and its arm's length bodies were responsible for making decisions that affected the social care sector. These individuals and the key decision makers within these departments changed several times during the course of the pandemic response and what was subsequently referred to as the 'pandemic recovery'.

125 With each change, Scottish Care had to re-establish contact arrangements and relations and secure attendance at appropriate meetings as decision-making retreated in-house or was reallocated to a new working group. This lack of continuity is itself evidence of the challenging landscape which existed at the time, however it resulted in a lack of consistent consideration of the independent social care sector in decision-making throughout the pandemic.

126 An example of this was when the PRASCG was disbanded in July 2022 and the new Social Care Systems Pressures (Silver) Group ("the Silver Group") was established in September 2022. The purpose of this group was to consider a national approach to pressures on the resilience of the social care sector. Despite Scottish Care having been actively involved in PRASCG, it was not initially invited to be a member of the Silver Group and as a result missed its first meeting.

127 There was also a demarcation between (1) the intent to consider the representations of Scottish Care and the interests of those that it supports when making decisions; and (2) capacity and capability to do this effectively. While Scottish Care's senior leadership team believes that the intent to consider the needs of the social care sector existed, the strategic direction, leadership, means and/or resource were often lacking.

128 From the onset of the pandemic, there was a reluctance to take into account the expertise or experience of those operating in the social care sector when decisions that affected it were being made. This resulted in a steady turnover of guidance relating to the provision of social care, including numerous guidance documents (and updated versions) being produced in relation to the management of care homes during the pandemic.

129 There was frequently a lack of understanding by decision makers of (1) the unique nature of the care home environment which is non-institutional and non-clinical - a care home is a resident's home and should be treated as such; and (2) the relevant considerations to be taken into account when supporting a population with significant behavioural needs and challenges.

130 PHS's distance and detachment from the sector was particularly evident throughout the pandemic. At the start of the pandemic PHS did not recognise that it needed input from the social care sector in order to develop effective guidance for the sector and it was initially reluctant to accept Scottish Care's input into such guidance – an example of this reluctance is described at paragraphs 137 - 139 below. It also did not appreciate the practical requirements of the sector, as was illustrated by its practice of issuing new guidance on a Friday afternoon as described at paragraph 143 below, and its approach in seeking to implement overtly clinical infection prevention and control measures in care homes as described at paragraph 99 above. As outlined above, Scottish Care was a vocal advocate on behalf of the sector however a number of the representations it made, such as those in relation to testing on admission to care homes and within social care settings and the mandatory use of face masks, were not acted upon with sufficient urgency to avoid detrimental impacts on social care providers and those in receipt of social care – many of which were severe.

131 On other occasions, Scottish Care and its members were not provided with sufficient opportunities to engage in the decision-making process. This resulted in decisions affecting the provision of social care being made without input from those with experience and expertise in the sector.

132 Some examples of decision-making practices which caused concern to Scottish Care are set out below.

Exclusion from the Gold Group

133 Scottish Care's repeated requests to Scottish Government officials and ministers for the independent social care sector to be represented in the Gold Group, which was responsible for key strategic decision-making in relation to the pandemic response, were consistently refused.

134 The failure to have the voice of care home and homecare providers at the table during national resilience planning meant that the resulting interventions were often insensitive to local circumstances and unsuccessful in meeting their objectives because they did not reflect the reality of the management of the pandemic for these providers.

135 It was not until autumn 2022 when the then Cabinet Secretary for Health and Social Care Humza Yousaf established a Ministerial Assurance Group to address winter pressures and delayed discharge challenges that Scottish Care and other provider representative bodies were invited to fully participate in key senior strategic planning.

136 The keeping of provider bodies at arm's length during the pandemic was a critical error and meant that opportunities to benefit from the knowledge and experience of the sector were repeatedly missed.

Opportunities to effectively contribute to decision-making

137 Scottish Care was approached by Health Protection Scotland (which was subsequently reformed as PHS) on 11 March 2020 about the dissemination of guidance to social care providers. Scottish Care was informed that there was an expectation that it would distribute guidance on infection prevention and control in

non-healthcare settings to care providers, links to which Scottish Care had shared with its members a few days previously.

138 Scottish Care asked to be involved in the production of sector specific guidance to ensure that it would be fit for purpose. This request was declined until 2.56pm on 12 March 2020 when Scottish Care was asked to comment on draft guidance for the residential care sector before 4pm that day.

139 As a result, "*the Nursing Home and Residential Care Residents and COVID-19*" guidance was issued on 13 March 2020 with only marginal involvement of Scottish Care. Issues of concern that arose subsequently were evidence of a lack of contextual awareness and knowledge which could have been provided by the sector had it been given an appropriate opportunity to contribute. These included issues regarding the ability to manage the support of an individual with advanced dementia in an isolated room; issues relating to the transfer of a COVID positive resident to hospital; and the role of primary care.

140 Additionally, Scottish Care repeatedly expressed concern at an early stage of the pandemic that there was insufficient guidance, including infection prevention and control guidance, for the care at home and housing support sector despite the obvious risks of community borne infection.

141 From mid-March 2020, the Scottish Government's engagement with the sector improved as Scottish Care was asked to participate in some strategic level meetings. Scottish Care accepted an invitation to join the Scottish Government's CPAG, which later issued updated versions of the guidance issued on 13 March 2020.

142 There were other interventions which allowed Scottish Care and some of its members to effectively contribute to strategic level decisions. A positive example of this was the creation of a working group in relation to PPE which worked with the sector to produce routes to access PPE of sufficient quality and which resulted in a helpline, PPE collection hubs and a delivery service being established.

143 However, at times engagement with Scottish Care by the Scottish Government and PHS felt tokenistic and Scottish Care's inputs, including simple practical requests, were not taken on board. By way of example, updates to guidance were often

released on a Friday afternoon, which required social care managers to work over the weekend to implement the changes. This compounded pressure and burnout in the sector. Scottish Care requested that the timing of the release of these updates was changed to reduce this pressure. While the official policy did change after some time, there were occasions on which PHS continued to issue guidance on a Friday afternoon - this suggested to social care providers that its compliance with its pre-determined schedule took precedence over the needs of the sector.

Lack of consideration of value, safety and rights of social care staff and those receiving care

144 There was initially no guidance or expectation that those working in social care should wear PPE yet those visiting people at home from clinical NHS settings were advised to wear gowns and masks. This caused confusion and also raised questions in relation to value and safety as it gave the impression that the safety of healthcare staff was valued over both social care staff and those individuals accessing care and support at home.

145 Such questions of value and safety were also raised in connection with decisions in relation to testing. Those receiving social care were amongst those most vulnerable to the virus however testing of such individuals and the staff that care for them was not prioritised in the way that it was for those in healthcare settings.

146 There were at times failures to recognise the valuable contribution that social care staff make to society when policy decisions were being made. For example, at the start of the first national lockdown social care workers were not recognised as key workers which resulted in staff being stopped by police on their way to work; uncertainty in relation to whether their children could attend school; and care staff being turned away from priority services being offered to key workers by the private sector such as priority access to petrol.

147 Separately, Scottish Care considers that the rights of those in residential care were not given adequate consideration when the Scottish Government was making decisions about the use and extension of national and local lockdowns. A failure to undertake a robust human rights and equality impact assessment of such

interventions, despite repeated calls from Scottish Care to do so, led to a limitation of the rights of residents and their families.

Rejection of accessible vaccine models

148 When the vaccine was developed, priority was given to care home residents from December 2020. Scottish Care dedicated significant focus to encouraging care sector staff to take up the vaccine and to addressing anti-vaccination messaging and myths.

149 Scottish Care continually advocated for more accessible models for vaccination to be adopted in order to make access as easy as possible for social care staff, for example by introducing peer vaccination by qualified nurses in care homes. Enabling clinical staff within care homes to vaccinate individuals would also have allowed residents to be vaccinated by staff that they knew and trusted which would have reduced the stressed caused, particularly to those with dementia.

150 The uptake of the vaccine amongst staff providing social care in the community was less than it could have been and Scottish Care called for the use of innovative models such as utilising community pharmacies in order to increase uptake. However, such practices were not adopted and an NHS dominant roll out was the preferred approach. Whilst this was effective in its first year, it increasingly failed to meet the needs of staff in care homes and the community in subsequent years and for boosters.

151 During the first roll out of the vaccination, care home staff were able to receive the vaccine in their workplace when the vaccine was also being provided to residents. However, when residents received their boosters, staff were often not offered their booster at the same time.

152 In subsequent roll outs, there was also a reduction in vaccine centres and for those living in remote areas this substantially reduced the accessibility of boosters. There are indications that lack of accessibility coupled with the rising costs of living and fuel has had a substantial impact on the number of people being vaccinated.

153 There was also a reduction in communications and media attention focused on the importance of staying up to date with the COVID-19 vaccine. Scottish Care asked

the Scottish Government to run campaigns that were specifically targeted to staff in social care, as it did during the first roll out. However, this approach was not adopted. Scottish Care ran its own campaigns in order to encourage social care staff to continue to be vaccinated but each vaccine roll out resulted in a reduced take up.

SECTION G: ENGAGEMENT WITH THE SCOTTISH GOVERNMENT THROUGHOUT THE PANDEMIC

154 Scottish Care has been asked whether it engaged with the Scottish Government when the Scottish Government was making decisions about its response to the pandemic. Scottish Care did so extensively throughout the pandemic, including by direct communication with Ministers, on working groups and in correspondence.

155 A high-level summary of Scottish Care's engagement with the Scottish Government together with a list of the formal correspondence which Scottish Care sent and received and the formal meetings at which it was represented is included at Appendix 1.

SECTION H: LESSONS THAT CAN BE LEARNED FROM THE SCOTTISH GOVERNMENT'S RESPONSE TO THE PANDEMIC

156 Scottish Care has been asked to provide a brief summary of its views as to the lessons, if any, that can be learned from the Scottish Government's response to the COVID-19 pandemic.

157 While further lessons will undoubtably emerge as the Inquiry progresses, the key lessons Scottish Care wishes to be learned at this stage in the recovery from the pandemic are set out below.

Inclusion of social care in pre-pandemic planning

158 It is essential that the independent care sector is included in strategic contingency planning for future pandemics.

159 The social care sector has specific characteristics and requirements that need to be taken into account so that a more cohesive and informed response can be delivered in the event of a future pandemic.

160 It is imperative that the Scottish Government and other key stakeholders engage directly with representatives who have expertise and experience in the sector so that the specific challenges that are likely to be faced by it can be appropriately taken into account in any response planning.

Recognition of expertise of social care sector in decision-making

161 More generally, it is important to recognise the expertise of the social care workforce and the real value its contributions can add when decisions that directly or indirectly affect the sector are being made. This will allow the sector to consider any unintended consequences that may arise from such decisions and to try to ensure that these are taken into account before such decisions are implemented. This is particularly important when decisions are being made to implement measures across a range of sectors and settings which may not be made with the unique landscape in which social care operates at their forefront.

Importance of viewing the provision of care through the lens of the service user

162 It is vital that when decisions are being made and implemented that the focus is on the needs and rights of those accessing care and support, as opposed to the type of organisation delivering the service. The focus should not be on whether the service is being provided in a healthcare or a social care setting and/or whether it is being delivered by a public body or by an independent provider commissioned by a local authority. Decisions should be viewed from the perspective of the end user to try to ensure that vulnerable people in society are getting the same protection regardless of where they live and what services they are accessing.

163 Taking the experience of service users, care home residents and their families into account is central to ensuring that services provided meet the needs and maintain the rights of service users.

The need for responsive and flexible financial support measures

164 Contingency planning for future emergencies should give consideration to how financial support and funding can be delivered to social care providers in a way which meets the needs of, and adequately sustains the long-term viability of, those operating in the sector.

165 Any model of financial support for the social care sector must:

165.1 ensure that there is a consistent national approach to the delivery of financial support across Scotland;

165.2 avoid additional pressure being placed on social care providers;

165.3 permit social care to access financial support that is commensurate to the funding available for businesses in other sectors without additional demands being placed on them during the application process; and

165.4 deliver the required funding without delay.

Importance of adequate PPE

166 PPE is a critical part of infection prevention and control and it is important to ensure that there are sufficient supplies available for both the health and social care sectors. Mechanisms to triage and deliver supplies across Scotland should be developed in accordance with the lessons learned throughout the COVID-19 pandemic.

167 PPE also impacts the practicalities of care delivery. It often affects interaction and communication with the people to whom social care is provided, particularly people living with dementia and people with hearing impairments. Consideration must be given as to what can be done to minimise any negative practical effects.

Testing

168 Testing must be used as a preventative method to control outbreaks as well as a diagnostic tool.

169 Given the vulnerability of those residing in care homes, it is essential that all individuals being admitted from clinical or community settings are adequately screened and tested as appropriate prior to being admitted to a care home.

170 Different testing implementation models adopted in different areas of Scotland led to inequalities in approach and timescales. Therefore a clear approach must be developed for application across the country subject to being tailored to address

specific local requirements (e.g. in remote areas or in areas with poor transport links).

Visiting in care homes and resident experience

171 As set out at paragraphs 65 and 66 above, while restricting visitors to care homes at the outset of the pandemic was proportionate to the risks at that time, the prolonged separation of residents from their families became increasingly disproportionate and caused significant distress to residents and their families.

172 In the event of another pandemic or national emergency, steps must be taken to ensure that care home residents are not isolated from their relatives for any significant period of time. Human Rights Impact Assessments should be used to inform any decisions to reduce, rather than prohibit, visitors to care homes where such measures are required.

Regulation

173 There is an opportunity to re-assess and re-evaluate the role of regulation in the social care sector, particularly in order to avoid duplication across different regulatory bodies and in relation to the provision of clear access to information to support improvement. Inconsistencies in information held on regulatory websites and the language used by each individual regulator should be reviewed to support access to consistent information via a centralised point.

174 The challenges associated with such duplication also extends to requests for information being made by different bodies which require responses in different formats. The potential to use technology to reduce bureaucracy, enhance efficiency and improve data should be explored.

Guidance

175 Keeping updated with constantly changing guidance was a significant challenge throughout the pandemic. The introduction of potentially conflicting information and short guidance implementation periods placed additional pressures on the social care sector, increased workload and heightened anxiety and stress.

176 A clear pathway for updating and communicating guidance throughout the social care sector should be developed.

177 Guidance should not be issued without consultation with the relevant sector. This will help to avoid unintended consequences arising from such guidance and will reduce the frequent need to update and replace guidance that developed during the COVID-19 pandemic.

SECTION I: RELEVANT DOCUMENTS

178 Scottish Care has referred to a number of documents throughout this response and can provide copies of these documents to the Inquiry on request.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 11th July 2023